[START 00:00]

(Music)

Mark Masselli: This is Conversations on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, interesting developments on the global health front. While the Zika virus continues to be a concern here, there's another health threat reemerging on the African continent, almost two years of no new polio cases, the disease has reemerged in Nigeria.

Margaret Flinter: This particular case occurred in Northern Nigeria; that is an area torn by war. An estimated 200 thousand children under the age of 5 in that region may not have received any single dose polio vaccine since birth and official, well they simply don't know how many more cases may emerge in this region.

Mark Masselli: Millions of polio vaccines will have to be administered by thousands of health workers with military protection across conflict ridden regions. It's scenario that illustrates just how challenging global health initiatives are to achieve, Margaret, but how vitally important they are.

Margaret Flinter: Well, you know, Mart, it's something we've actually seen right here in this country. We certainly have a subset of parents who chose not to vaccinate their children. That has paved the way for a resurgence of childhood diseases like mumps, and whooping cough, or pertussis and since we are entering the back to school time of year, this is a good time to remind folks, get your kids vaccinated; the benefits unequivocally outweigh the risks.

Mark Masselli: No question about it and another thing that mitigates health risk is gaining health coverage; something our guest today is quite expert about, Dr. Benjamin Sommers, is one of the nations leading experts on the impact of uninsured Americans gaining coverage. His most recent research shows a direct and dramatic impact on population health.

Margaret Flinter: And Lori Robertson will stop by, the Managing Editor of FactCheck.org.

Mark Masselli: But, no matter what the topic, you can hear all of our shows by going to chcradio.com or as always if you have comments, please email us at chcradio@chc1.com or find us on Facebook or Twitter; we'd love hearing from you.

Margaret Flinter: We will get to our interview with Dr. Benjamin Sommers in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's headline news.

(Music)

Marianne O'Hare: I am Marianne O'Hare with these healthcare headlines. The dramatic price of the EpiPen has caused alarm across the country, the popular easily administered intervention for kids and adults having life-threatening allergic reactions went from $100 in 2008 to $600 this year and lower cost competitors have failed to gain FDA approval. Washington law makers have demanded answers from executives at Mylan laboratories makers of the EpiPen calling a price hike as outrageous. School health officials across the country are worried about the potential health crisis if budgets don't allow them to stock enough of the life saving devices. Asthma and serious food allergies are on the rise among school-aged children. Mylan CEO, Heather Bresch said her company has spent hundreds of millions of dollars improving the EpiPen, while not reducing the cost of the product, she did bow to public pressure announcing a credit program that will provide discount cards for those who have to pay higher out of pocket costs for the life saving treatment. Zika continues to impact the Florida costal regions with Pinellas County on the West Coast being added to the already hit East Coast areas around Miami and in addition to the CDC warning that pregnant women should avoid the region to protect their unborn fetuses, CDC officials also concerned the recent epic flooding in Louisiana could lead to an outbreak there as the mosquitoes responsible for carrying the virus breed very efficiently in just a tiny bit of standing water. Meanwhile, that same mosquito, the Aedes aegypti mosquito is being blamed for an outbreak of Yellow fever in parts of Angola and the Democratic Republic of Congo. Not all who become infected fall ill, but about half of those who do will die from the infection for which there is no cure. The massive vaccination effort underway has depleted the World's standby supply of Yellow fever vaccine, a concern to officials at the World Health Organization. Contact lenses are in widespread use in this country. About 41 million Americans improve their eyesight with them, but such ubiquity also makes many users a little too casual in their upkeep. The CDC reports more than a thousand cases of contact lens related eye infections leading to some vision loss or the need for corneal transplants. The CDC urging contact lens users never to sleep in their contacts even if they are the long-wear type. In addition, official caution never to wash them with simple tap water, always using the appropriate disinfectant. I am Marianne O'Hare with these healthcare headlines.

(Music)

Mark Masselli: We are speaking today with Dr. Benjamin Sommers, Health Economist and Physician, whose main research interest in analyzing health policy for vulnerable populations and the uninsured. Dr. Sommers is a practicing primary care internist and is an assistant professor of medicine at Brigham and Women's Hospital and Harvard Medical School. He has served as senior advisor at the Department of Health and Human Services and has won numerous awards for his work including the Alice Hersh New Investigator Award, here into his PhD in health policy at Harvard School of Public Health and as M.D. from Harvard School of Medicine. Dr. Sommers, welcome back to conversations on healthcare.

Dr. Benjamin Sommers: It's a pleasure.

Mark Masselli: You've been focusing much of your award winning research on the impact of gaining insurance coverage with a real focus in on the Medicaid expansion and now we've had so much transition; millions more Americans have gained coverage and I am wondering if you could give our listeners an analysis of how the National Coverage landscape has lived up to the expectation among those who help craft the policy.

Dr. Benjamin Sommers: The coverage expansions have been very successful and have been quite in line with what those who worked on the policy were hoping. The estimates are that about 20 million more Americans have health insurance today than would if the law hadn't been passed and that's a huge change. That's the biggest gain in coverage over a short period since the passage of Medicare or Medicaid in 1965. So, it has succeeded in that regard. Now, it hasn't been unequivocal success and I think the first shortcoming that I would point to compared to what those who drafted the law and for those of us working on it early on in the implementation period, were surprised and disappointed by was the Supreme Court ruling that left it open to States as to whether to expand and the fact that you know, nearly 20 States have still yet to do so and this may account for anywhere for 3 to 4 million low-income adults in these States, who simply have no way of getting health insurance. They can't qualify for subsidies on the marketplaces and the law just never really envisioned this scenario and so people in this Medicaid gap are really left behind and it is quite worrisome that the folks who are left out of the coverage expansion of the ACA are some of the poorest people and some of the poorest States in the country.

Margaret Flinter: Well, Dr. Sommers, I wonder first if I could sort of bring our attention to the article that you recently published in the New England Journal of Medicine and I was really responding to the warnings of dramatic rate increases for the insurance marketplace plans for 2017, some insurers have submitted significant double digit rate

hike requisition, but you are making a very important point that the sky is not falling on Obama care and that there are safeguards in place to make sure the consumers aren't hit with a dramatic rate increase. Share with us what are some of those safeguards?

Dr. Benjamin Sommers: These reports that are coming out and have come out actually, every spring for the past three years are related to the initial rate requests that the insurance company submit. These rate requests are subject to approval by the State and Federal Government under the rate review part of the ACA and so any plan that is requesting more than a 10% increase in premium have to submit documentation and justify why they are doing that, what their expected costs are, and then the regulators decide whether or not that's an appropriate increase. In last year, the estimate was that about 30% of people in marketplace plans actually have their rates held down by this process. There is also a lot of competition in the marketplace, as at least in many parts of the country and so plans that submit really high increases, out of proportion than other plans are doing, may end up losing a fair bit of market share and then probably the most important safeguard in place for the majority of people in the marketplace is that they are getting tax credits to help them purchase coverage and the tax credits are paid to a flat percent of their income, so if your premiums are capped at 5% of your income, even if the premiums are going up significantly this year compared to last year, the tax credit will actually cover most of that or all that increase in many cases. We have seen this kind of alarmist trend in some of the media coverage in the past several years on this, but when you circle back by December, the past years, the premium growth has been below historical rates. So that's just important context for people to get in line.

Mark Masselli: So, this guy is not falling, but there are clearly some titanic shifts going on in the insurance marketplace. We are reading everyday of large insurers such as United Healthcare and Humana have announced that they are pulling out of the exchange citing the financial risk that is just too great for their bottom lines and I am wondering if you could sort of give us a better sense of the landscape within the insurance industry.

Dr. Benjamin Sommers: The issue of plans dropping out, has I think a couple of factors that have to be looked at. The first is the individual insurers are often engaged in their own strategic reassessments and it is tied into these proposed mergers that are receiving scrutiny from the Federal Government. It doesn't necessarily translate that a big insurer, where they are providing a lot of Medicaid, a lot of Medicare advantage, a lot of private plans or employer plans are also necessarily the biggest in the marketplace. So, United Healthcare often gets described as the nation's largest insurer, which it is, but it has never been one of the bigger insurers in the marketplace and in fact, it set out the first of the marketplaces and then it has been, you know, marginally significant player in some market, but there are some areas of the country, in some States, where the number of plans is less than you would want it to be, in terms of competition and keeping down premium prices, but there are some places where that doesn't seem to be happening and that's something that those States need to look at and try to figure out ways to improve this and also Congress ideally will start to revisit

some of the pieces of the law that either expire after 2016 or are shaping the competitive landscape. For sure, I think consumers generally will benefit if they have multiple plans to pick from, both in terms of what plan is a good match for them and how much they pay for it.

Margaret Flinter: Uh-um, Dr. Sommers you recently released findings from your longitudinal study that compared the health status of the population and States that expand Medicaid to those low-income individuals, we were talking a few moments ago or provided a low-cost option for State residents versus the States that did not expand their coverage to their uninsured low-income residents and you talk about the different approaches taken and what kind of outcome each approach had on population health. What kind of impact, specifically, are we seeing in vulnerable populations?

Dr. Benjamin Sommers: In this case, we are looking at three States that have had different approaches to the ACA expansion. So, in Kentucky, we looked at a State that was doing traditional Medicaid expansion and in Arkansas, they were doing something innovative called the private option, where they took the Federal Medicaid dollars from the ACA and brought private insurance for their low-income population and then, in Texas, they didn't do any expansion. In the first year, we saw big gains in coverage and some improvement in affordability, but it was really in the second year that we started to see broad-based improvements along a whole host of domains related to healthcare access, more outpatient visits, more primary care in the Medicaid and private option expansion States. More people say that their quality of care was better. They are getting more prevention like diabetes checks, and overall, in those two expansion States, people started to even feel better. The percentage of people that said they were in excellent health in Arkansas and Kentucky rose relative to Texas, where coverage wasn't being expanded, so an early indication that the coverage expansion is producing a lot of benefit and not only financial benefits, but quality of care and perceptions of health.

Mark Masselli: We are speaking today with Dr. Benjamin Sommers, a practicing primary care internist and assistant professor of medicine at Brigham and Women's Hospital and Harvard Medical School, whose primary research focuses on health policy. The Center for Medicare and Medicaid released a report recently showing that health costs for those who would gain coverage on the insurance exchange remained relatively flat in 2015. Yet, the Urban Institute, the Commonwealth Fund, and others have concluded that more consumers are purchasing high deductible plans with very large out of pocket expenses, which are leading many to forgo even necessary health services. I am wondering if this is around education or are there other reasons that are scaring people off?

Dr. Benjamin Sommers: Yeah, the high deductible plans that we are seeing frequently in the marketplace are not a new thing. They have been increasingly used among employers with the offering of employee insurance as well, but it is a general trend that we have seen over the past decade and in the ACA, certainly evident in the marketplaces. So there are some good arguments that you want some of these plans

to be out there. Some people may say, I don't have a lot of healthcare needs or I'd rather pay a lower premium in exchange for, you know, a plan that does have these deductibles, but it lets me save some money. Many years of studies have been done including way back to the Rand Health Insurance randomized trial back in the 70s that showed that these deductibles and co-pays can help hold down total cost and without necessarily hurting population health, but that may ignore what's happening to some of the more vulnerable people in the population and in particular, people with chronic conditions and lower income adults do seem to suffer by avoiding some of the care that they really need if they are facing high out of pocket spending and so there is a balance that we need to strike. Eliminating deductibles entirely from the marketplace would cause premiums to go up pretty prohibitively, but you do want to make sure that people can get preventive care, which the ACA specifies is without cost sharing and your mammograms or your Pap smears or colonoscopy and your well-child visits, the ACA requires those to be covered without any deductible or cost sharing, but then there are also things that are not prevention, but are still really important; you know, managing people's high blood pressure, helping people stay on their medications for heart disease or diabetes and we are starting to see some of the plans looking at options to help hold down the cost sharing for those issues to help people keep their health in good shape and manage their chronic conditions. They can end up being pennywise and pound foolish to charge people upfront a lot to do the kinds of care that we know they need to stay healthy in the long run.

Margaret Flinter: Well, Dr. Sommers, if you will, I am going to divert a little bit from the focus on coverage for a moment to focus on the world that you find yourself in is part of a venerable teaching institution that's having to respond to so much change, everything is changing, health policy, care delivery models, biomedical science, and all of that's got to have a big impact on medical training. How have you seen all this change impacting the design of medical education?

Dr. Benjamin Sommers: Yeah, it really has been a whole decade of tremendous change in Massachusetts Healthcare, because it's back to 2006, when the State passed its own healthcare reform, which became the model for the Affordable Care Act. Since that point the State has moved to near universal coverage, but at the same time, has started to try to tackle some of the challenges with healthcare cost and so there've been some innovative payment models here that then we are now seeing applied more broadly onto the Affordable Care Act and things like Accountable Care Organizations. You know, I think the jury is still out on whether this is the answer to our healthcare cost issue. It is certainly promising in that in the right setting, these sorts of payment models that get away from just volume and fee for service do seem to produce some savings, but they are modest. It's not cutting, 20% of healthcare costs that may be some people think are overuse. We are not getting rid of that in a snap and in terms of the curriculum that we train in, there is still a really attention between the way doctors are trained and in the way that they are encouraged to practice in the broader socially conscious way that may be many policy makers think they should. In the residency process, in the medical school process, it is still the case that you are taught a lot of hard science, where you are pushed to figure out the most interesting and difficult cases and to take

advantage of the newest technologies, which are often quite expensive and meanwhile, when we look nationally at how much we are spending on healthcare, a lot of those things that in the individual case are kind of fascinating new technologies and the aggregate drive up cost and we have to figure out how to balance that tension. I am a practicing primary care doctor and I spend a lot of time, when I am seeing patients confused about some of the framework that I am paid under and some of the programs that we are participating in because the landscape is moving so much and so, you know if I as a primary care physician is also a health economist finds some of this confusing at times; I imagine that I am not the only one.

Margaret Flinter: What hope is there for mere mortals?

Dr. Benjamin Sommers: Yeah, I am not the only one.

Mark Masselli: Well, we have an election on the rising. You've spent a considerable amount of time really focusing on the 20 billion Americans, who've gained health coverage. I am wondering how you and your colleagues are looking at the horizon in terms of health reform. What shifts in the current policy do you anticipate?

Dr. Benjamin Sommers: This is really the first election in six years, may be even eight years, where large scale change to the healthcare system hasn't been a focus. We are hearing a lot less about repealing at the ACA. Now, candidate Trump does talk about that. Some candidates for Senate in Congress on the Republican side are still talking about repealing the ACA, but it is not of central part of the argument, where they can pay in most places and that's really kind of interesting. You know, I think a lot of policy and political analysts expected that once a law was in effect and millions of people are gaining coverage, this debate would die down. In 2014, you know, there was still quite a lot of debate about it, but it may be that at present Obama's term is winding down and there will no longer be an Obama in Obama Care, I think in terms of overseeing the law that we start to move to what usually happens with large scale policy changes, which is that they get passed and then they get revisited. We see proposals to improve them, scale them back, but not just a simple repeal or not repeal argument, which is really where we've been for the past, you know, six years. So, I'm being optimistic that we will start to see some meaningful conservation or ways to improve the law without devolving into just black and white perspectives on it and we see some of that out of the Clinton campaign. They've talked about adding a public option and trying to tweak prescription drug pricing, but building on the ACA and revisiting and I think that's constructive that we ought to be talking about ways to improve the law, because it seems to be working pretty well in terms of coverage and access gains, but it's certainly not perfect.

Margaret Flinter: We've been speaking today with Dr. Benjamin Summers, Health Economist, practicing Primary Care Internist, and Assistant Professor of Medicine at Brigham and Women's Hospital and Harvard Medical School. You can learn more about his work by going to hsph.harvard.edu/benjamin-sommers or follow the Harvard School of Public Health on Twitter@Harvardhsph. Dr. Sommers, thank you so much for joining us on conversations on healthcare today.

Dr. Benjamin Sommers: My pleasure, thanks so much.

(Music)

Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori what have you got for us this week?

Lori Robertson: Hilary Clinton got a clean bill of health from her doctor, but fake medical records for the Democratic Presidential nominee are circulating on some conservative websites. These bogus documents purport to show that she suffers from seizures and dementia. Clinton's long-time physician released a statement at FactCheck.org calling the document false and reiterating her diagnosis that Clinton is "in excellent health and fit to serve as President of the United States." The doctored document plays off Clinton's very real concussion in December 2012, which caused her to suffer double vision for nearly two months. Her physician Lisa Bardack, Director of Internal Medicine, Mt. Sinai Health System at CareMount Medical says follow-up medical exams in 2013 "revealed complete resolution of the effects of the concussion." The fake documents appear to have originated from a since deleted Twitter account and purport to come from Dr. Bardack, but the wrong title on the letterhead. In her statement provided to us, Dr. Bardack said these five-year-old documents are false and "were not written by me and are not based on any medical facts." Dr. Bardack, who has served as Clinton's personal physician since 2001 did publicly release a summary of Clinton's health history and a medical evaluation in a letter dated July 28, 2015. It says Clinton is a "healthy 67-year-old female, whose current medical conditions include hypothyroidism and seasonal pollen allergy." Republican Presidential candidate Donald Trump has questioned Clinton's mental and physical stamina, but the baseless speculation is also refuted by the public statement and medical evaluation released by Clinton's long-time doctor and that's my fact check for this week. I am Lori Robertson, managing editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact, that you would like checked, email us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Healthcare.

(Music)

Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Sub-Saharan Africa leads the world in maternal and infant deaths each year. According to an annual report from Save the Children, an estimated 397 thousand babies died at birth in that region in 2013 and some 550 mothers died per day as well. Most of the causes have to do with lack of access to medical care in these low resource regions and often the local midwives lack formal medical training to prepare them to conduct interventions in the event of a life-threatening like a hemorrhage or an infection.

Anna Frellsen: We know that 90% of all the deaths that we see today could be prevented if the mother had, you know, access to this really basic skill care during the childbirth.

Margaret Flinter: Anna Frellsen is CEO of the Maternity Foundation. A Copenhagen based nonprofit, dedicated to eliminating maternal and infant death in the world. Their organization has created intervention for midwives living in low resource areas. If they just have access to a smart phone, it's called the Safe Delivery App and it provides comprehensive training for midwives that teach them and guide them on what to do in the event of a birthing crisis.

Anna Frellsen: This is really a matter of building the skills of the health workers, who are already out there and empower them to be able to better handle the emergencies that, you know, may occur during childbirth, such as, you know, the woman starts bleeding or the newborn is not breathing and so forth.

Margaret Flinter: Frellsen says the real promise of the Safe Delivery Application lies in its ability to provide ongoing obstetric and neonatal training, so that local midwives can gain important clinical knowledge over time. The Safe Delivery App has been designed to be culturally relevant and easily understood and it has received the United Nations approval for wider deployment. The Maternity Foundation plans to have the Safe Delivery App in the hands of ten thousand healthcare workers across the region by next year, potentially impacting a million live births; a low-cost culturally sensitive mobile app that offers immediate guidance and assistance to midwives and health workers, the backbone of the healthcare system in low-resource areas that can improve birth outcomes, now that's a bright idea.

(Music)

Margaret Flinter: This is Conversations on Healthcare, I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Conversations on Healthcare, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.

[END 25:00]